MONTANA DEPARTMENT OF CORRECTIONS
GREAT FALLS YOUTH TRANSITION CENTERS
PRESCRIBED MEDICATION REFUSAL FORM

DATE: _____

YOUTH'S NAME: _____ **YOUTH ID**: _____
(Please print)

I hereby voluntarily refuse to take the following prescribed medications: _____

_____

_____

_____

_____

Youth's Signature: _____

OFFICER'S REPORT

DATE OF REFUSAL: _____

BRIEF REASON: _____

_____

_____

_____

_____

_____

_____ _____
Signature of Reporting Officer *Officer's Location*

_____ _____
Signature of Second Staff Member *Title*
(Required only if youth refuses to sign form)

_____ _____
Signature of Prescriber *Date of Review by Prescriber*

***** IMMEDIATELY NOTIFY CENTER DIRECTOR OR DESIGNEE *****